FAMILY INTERVENTIONS FOR PROMOTION OF HEALTHY CHILD DEVELOPMENT

A TRAINING MANUAL FOR PRIMARY HEALTH WORKERS

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A Training Manual For Primary Health Workers

For Ravi Narayan

With Compliments

10/11/08

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FOREWORD

The family forms the basic and most important unit of society. A child's emotional and physical development is to a large extent influenced by the nurturance and stimulation she receives from the family. It is also known that children from 'high risk' families form a vulnerable group for developing emotional and developmental problems. These children are often 'invisible' as they are usually in rural or slum areas and may never approach child care personnel. Identification and intervention in such families in the community hence forms an important cornerstone in primary prevention.

This manual is aimed at helping health workers in (a) identifying and detecting families at 'high risk' for poor psychosocial development of children and (b) intervening in these families using simple family counselling techniques. This manual is meant for basic health workers and Anganwadi workers working in the community, and has been made as user friendly as possible. It has been field tested and appropriate changes have been incorporated in this version.

I hope this manual will help all professionals who are working with chidlren, women and families in the community.

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Introduction

Child health forms one of the important components of health planning in our country. Though a number of child care programmes have been formulated to promote physical development, there has hitherto been minimal emphasis on the psychological and social aspects of development. In order to achieve healthy child development in a global form, it is necessary to incorporate various psychological and social interventions into the existing programmes dealing with nutrition, infection control and immunization.

Most child care programmes focus exclusively on the mother and her potentials in adopting newer methods of child rearing. However, very often because of the presence of adverse factors in the family and environment, the mother is unable to incorporate and utilise the important knowledge. It is hence essential that the target person in child development programmes (i.e., the mother) be viewed in the context of her immediate family and neighbourhood and any problems in those areas be resolved. This can be achieved only if the whole family is involved in the intervention process.

There are two important ways in which family intervention and involvement helps in child development.

1. The family forms the basis of an individual's life and to facilitate any change in the individual it is necessary to make changes in the family. Work on child development has convincingly demonstrated that mothers play an important role. Any change in the mothers attitude or functioning can be brought about only through the family's cooperation and change.

2. The other important aspect of family intervention is the fact that the intellectual, emotional and social functioning of a child is to a large extent modulated by the family. The family's life style and ways of functioning have to be healthy in order to promote optimal development in the child.

This document aims at helping the user acquire knowledge about healthy psychosocial development of the child, the factors affecting it and also helps the user in acquiring skills to make necessary interventions in the family.

The main objectives of this manual are :

1. To enable the user to acquire knowledge about
   a) Healthy emotional and cognitive development.
   b) The role of the family in healthy psychosocial development.
   c) The various factors that adversely affect a child's development.
2. It helps the user in identifying families 'at risk' for poor psychosocial development of the child and assessing the nature and extent of the family problem.
3. It helps the user in acquiring skills of family intervention through simple counselling techniques and alleviating the risk factors.

CHAPTER - 1

Guidelines to the Trainer

As part of the Governmental Health Services in India, various programmes exist in Rural, Slum area and Urban areas to better child and family health. The family intervention proposed in this manual is meant to reach children at risk of poor psychosocial development. Risk assessment and subsequent intervention strategies can easily be integrated into the training programmes and routine tasks of health workers. The learning of these new skills will help them to counsel the families with regard to their risk factors and improve coping skills. The aim is to use the young mother as a means of entering the family system and bring about changes in the family.

This means that any health worker can act as an intervention worker. The trainer would need to familiarize himself with the manual before initiating training. Our manual contains the following chapters.

Chapter II : — Normal Psychosocial Development of the Child.

Chapter III : — Role of the Family in healthy Child Development.

Chapter IV : — Identification and Assessment of 'High Risk' Familes.

Chapter V : — Family Intervention – General Guidelines – specific interventions.

Chapter VI — Illustrative Cases.

Chapter VII : — Outline of steps in family intervention.

Chapter VIII : — Integration of family intervention into existing health services.

The intervention worker needs to be trained in the following aspects.

1. Training the intervention worker in identifying the 'at risk' families at field level and detailed assessment of these risk factors.

2. Training to identify various resources within and outside the family that can be utilized in intervention.

3. Training in actual intervention at field level – with the families. Care should be taken to follow the steps listed out in Chapter VII of this manual.

The trainee can start the intervention by herself/himself once she/he feels confident of handling it. The trainer should give sufficient chance for discussion regarding various doubts that may arise in the mind of the trainee. It would be useful to compile a few case vignettes (at least 10) from the actual families seen by the trainee. These may be checked for the correctness of decisions taken by the trainee, appropriateness of the interventions and the steps followed. The flaws may be discussed and if any vignette is unsatisfactory, fresh ones may be compiled. These methods enable even an inexperienced person to learn better and faster.

Evaluation of Training

The training can be evaluated at periodic intervals (usually 3-6 months). Evaluation of training is made by assessing the number of risk families identified by the trainee, the risk factors detected, assessment of the family problem and the nature of intervention planned. These would be the process indicators. Outcome indicators which will evaluate effectiveness of the training would be the improvement in family functioning measured by decrease in the number of risk factors, satisfaction of the families in which intervention is made, improvement in well being of the family members, cognitive/behavioural functioning of children and an improvement in nutritional status.

CHAPTER - 2

Normal Psychosocial Development of the Child

Assessment of growth and psychosocial development is the most powerful tool for early identification of children who may not look obviously sick but who, nevertheless have suboptimal health and nutrition and are suffering from latent illness. Remedial measures undertaken at this stage are useful for prevention of long term problem.

In this regard it is not only the motor development or the physical growth which should be considered, instead a global development should be emphasized, an important ingredient of which is the psychosocial development.

From the birth of a child upto 2 years of age, this may be called his babyhood. The just born baby starts his vocalization with a cry. But normally cries in infancy are in response to physiological condition of the infant like hunger, pain, discomfort or fatigue. It is like a reflex because his awareness of the environment is not clear. He starts babbling from 2nd or 3rd month onwards and this reaches a peak in the 8th month. It is more a playful activity than communication. He usually uses gestures as a substitute for speech.

The baby's emotion may be divided into two groups – pleasant or positive and unpleasant or negative. There is only crying and screaming at birth. During babyhood, emotions are short lived but very intense. They appear frequently but disappear when the baby is distracted. The common emotions in babyhood are anger and fear. Thwarting of a wish or interference in his activities normally brings out anger. Too much of this may later lead to aggressive behaviour. Fear reactions are usually associated with the native fear of loud noises or falling. At the end of babyhood fear of animals, dark places and being alone appear. Sometimes the child adopts fear reactions through imitation. The baby also experiences pleasure or joy at his own activities and he smiles and sometimes even laughs. At around 2 years his smile accompanies verbalization.

The baby shows his affection normally by hugging, patting or kissing the loved object or person. Affection develops primarily in relation to people and is normally directed towards familiar persons.

The home environmnet plays a vital role in his social development. His social behaviour at different stages consists of turning to voices, smiling, imitation of speech, gestures, reacting differently to different situations, cooperating and so on. His play in the begining consists of stimulating his sense organs, later playing with toys and other children. In his babyhood he is mostly an onlooker and plays parallel to other children.

He learns concepts by sensory exploration like listening, touching, smelling etc. In his babyhood, he learns about reacting to colours. Foundations of moral behaviour are laid in babyhood. His personality is formed from interaction with the parents, siblings, other family members and his environment. Babyhood is a critical period in personality development because the foundations are laid now and upon this his personality will be built as he grows into an adult.

2-6 Years

The period between 2 and 6 years may be called early childhood. This is the preschool age. Now the child is no longer a spectator, he wants to explore and he is more independent. His vocabulary increases rapidly, partly due to teaching and partly due to curiosity. He learns specific words.

During this stage emotionality is very high like temper tantrums and intense fears. The common emotions experienced at this stage are anger, fear, jealousy, affection, curiosity and joy. Anger is very common and is expressed through temper tantrums characterized by crying, screaming, kicking, falling on the floor etc. Fears also increase at this stage because the child recognizes the potential dangers better. Jealousy appears as an angry resentment towards people, for eg., towards a new arrival, sibling etc. Jealousy decreases as the child's interest broadens but excess of this may sometimes lead to neurotic traits like thumb sucking, bedwetting etc. This period is usually called a 'Questioning age'. They are curious about their own bodies and that of the adults. He experiences joy when he discovers something new and teasing and playing are common. He expresses joy with smiling, laughing, jumping and clapping hands.

In the home the child learns to love and to be loved. This determines his success in his later relationships. Social behaviour starts at this age and will be in the form of negativism, imitation, rivalry, quarrelling,

co-operation etc. They usually have the parents as models to imitate. When they are frustrated, they show aggressive behaviour. They usually have a desire to excel and hence rivalry arises with peers or siblings. When they do not like adult authority they show negativism. Usually children quarrel a lot due to their self-centredness and they try to be bossy. The co-operation with others is very less at this stage.

This is the 'Toy age'. The type of play is influenced by sex and intelligence of the child. The child likes to play with children in the neighbourhood. When alone, imaginery playmates are a common characteristic. He identifies his own sex and sex appropriate roles. Ability to understand thoughts and emotions are quite accurate.

His interests surround mainly him and his possessions. He likes to dress well because it attracts others. Mother plays a more important role in the child's life than any other person. Her attitude towards him and her treatment of him play major roles in his personality development. He learns to think and feel about himself as defined by others especially parents, siblings.

Chart of Milestones

2 months	—	Turns to human voice, Beginning of social behaviour.
3 months	—	Shows interest in people, plays with toys, kicking bouncing, reaching for his toes, watching his fingers move very strong stimuli attract his attention.
4-5 months	—	Smiles in response attracts other babies with kicks and blows, differenciates smile and scolding calling added to crying. Says 'da-da' 'ma-ma', reaches out for objects.
5-8 months	—	bouncing, headshaking, squirming, pulling to a standing position.
8-9 months	—	Attempts to imitate speech, gesture and simple activities.
9-12 months	—	Develops fear of strangers, crawling for a toy, climbing, moving furniture. Drinks with cup, understands spoken words. eg 'where is mother' etc.
12-16 months	—	Runs away when frightened, listens to warnings like 'No'.
18 months	—	Smiles at his own activities, play is solitary, onlooker when other children are playing.
18-21 months	—	Little social give and take play parallel with other children, able to say three words or more, able to

remove garments, can point to one body part, feeds himself with a spoon.

2 years — Pre-occupation with self, play more organized, smiles in relation to other person and is accompanied by verbalization. Toys are his 'love objects', climbs steps, puts on clothes and slippers, washes and dries hands, and can use pronouns like he, they, 1 etc.

2-3 years — Peak of jealousy, questioning age.

3 years — Complete sentences of 6 to 8 words appear frequently, plays with other children, dresses and undresses completely, holds and postpones his bowel movement.

3-4 years — Infantile pronounciations disappear.

4-5 years — Identifies his own sex and appropriate sex roles. Aggression more verbal, names colours, learns the meaning of numbers, interested in playing with neighbourhood children.

6 years — Knows how to count, questionning reaches its peak.

Cognitive Development

I Perception — At Birth Vision – develops late Auditory Structures – more advanced Taste – Can discriminate, particularly sugar

At 1 month — Looks more at vertical stripes

3 - 4 months — Prefers curved elements to straight lines

6 months — Differenciates female faces from male faces.

6 - 7 months — Reaching out for objects, can tell familiar faces from unfamiliar ones.

7 - 12 months — Avoids visual cliff.

Attention

2 - 4 months — Novelty of the stimulus attracts attention.

12 months — Concept of 'face' is very firmly established.

18 months — Notices the discrepancy between objects.

4 years — Novelty is not a major factor in drawing attention.

Language

1 month — Able to make fine discrimination between speech sounds.

3 months	—	Can respond differently to different ways of speech (eg. baby talk), vocalizes sounds when the mother speaks.
8 months	—	Understands simple commands.
1 Year	—	Associates familiar objects with specific words, says bye bye.
2 years	—	A vocabulary of around 200 words.
3 years	—	Sufficient vocabulary to meet immediate life needs.
5 years	—	Can communicate complex thoughts.
6 - 6 1/2 years	—	able to read and understand spellings.
Memory :	—	At birth – Memory is a conditioned response
18 months onwards	—	Immediate memory is developed.
3 years	—	Imagination develops

Thinking and Reasoning

1 year	—	Shows little problem solving behaviour, upto 7 years no logical reasoning.

CHAPTER – 3

Role of the Family in Healthy Child Development

The family has been society's primary agency in providing for the child's biological needs such as food, clothing and shelter and simultaneously helping in the development of the child into a well adjusted, emotionally healthy person.

The family must foster and direct the child's development by carrying out a number of functions:

1. The care giving role which caters to the child's physical and emotional needs.
2. Helping the child develop an adequate and healthy personality.
3. As a model for learning basic social roles and mores of society.
4. To transmit the cultural aspects of life.

These functions will now be described in detail

1. **The care giving function :** This includes the care given from a helpless neonate to an adolescent's more mature needs. It concerns fulfilling the child's basic physical needs and his emotional needs for love, affection and a sense of security. Proper nurture requires the parents to have the knowledge and capability of managing a child at different stages of his development. A nine month old child's needs are different from that of a 3 year old and a healthy family is able to change itself based on a child's needs.

Usually, it is the mother who is the primary care giver, particularly in a small child, however the relationship with the child is clearly related to the whole family situation and is influenced by it. A mother's capacity to nurture will be influenced by her marital interaction with her husband, relationship with her neighbours and relatives and demands made by other children. A father also profoundly influences his children's behaviour both directly and indirectly by his relationship with the mother. A woman's

capacity to nurture her child is largely dependent on the emotional support she receives from others in the family.

2. Helping the child develop a healthy personality

For the child to develop an integrated personality and to form gender identity, the family must provide him with an opportunity to observe healthy roles among parents and siblings. The family members through their complementary roles, leadership patterns and gender specific functions act as models for qualities such as sharing, abiding by rules and living in harmony.

For this, it is essential that the parental unit is strong and without conflicts. If the parents form a unit not only as parents but as a married couple, the child is provided with healthy adult models. A strong parental unit with healthy communication between the various generations provides the child with strong emotional security.

If this does not occur the child is subject to many conflicting standards and values and is unable to achieve a healthy personality.

3. The family as a social system

The family is the first social system that a child knows and into which he grows. He gains familiarity with the basic roles such as that of a parent and child, husband and wife and the responsibilities that go with each role.

The family value sytems, ideas regarding reward and punishment, monitary transactions, sharing and togetherness and the value of authority are some of the aspects of life that a child learns through his family.

4. The family and culture

It is the family which provides the initial steps towards culture specific matters such as food preferences, styles of dress, play and games, religious beliefs, language, music and other areas of intellectual stimulation. A child's first teacher is always the parent or a parent substitute and a large part of the child's life is spent in his initial school i.e. the family. An inportant part of his psychological development i.e. the intellectual and cultural development has its roots in the family.

A study of these four areas of the family's role clearly indicates the importance of the family and parental unit, how they behave and communicate, how they relate to one another and to the child and the emotional security and warmth that they offer. Stability and harmony in a family is the ideal setting for a child's healthy development.

CHAPTER – 4

High Risk Families: Identification and Assessment

High risk families are those which as a result of their atmosphere and circumstances lead to physical emotional, intellectual or other developmental problems in their children. Children belonging to these families are more vulnerable than their counterparts, to develop problems. It is important hence to identify these families and intervene at an early stage in order to prevent problems in the children.

The Psychosocial Factors that lead to high risk can be divided into 3 main groups –

1. Socio-cultural factors.
2. Factors related to family interactions and organization.
3. Factors related to ill health.

1. SOCIO-CULTURAL FACTORS

a) Socio-economic difficulties

b) Belonging to a minority group.

c) Migration

a) **Socio-Economic Difficulties** – Economic difficulties render a family incapable of meeting all the needs of the child. The parents are so busy making ends meet that the child suffers from deprivation in all areas – food, clothing and intellectual stimulation. Overcrowded housing, unclean neighbourhood and inadequate place for play are some of the reasons why children from these families are vulnerable in terms of physical and psychosocial growth.

b) **Belonging to a minority group** – These children by virtue of their community might feel isolated and may not be given ample opportunities for schooling and access to intellectual stimulation. They

may also suffer from low self esteem based on their status in society which automatically puts them at a disadvantage.

c) **Migration** – Parents who have recently migrated or are in the process of migrating, themselves go through stress because of which they are unable to satisfy the emotional needs of their children. Uprooting from their places of origin, finding new jobs and the lack of social groups in the new place make these families isolated which has its influence on the children.

2. FAMILY ORGANIZATION AND INTERACTIONS

a) Interaction

As noted earlier in the manual, the stability of a family is one of the most important factors in healthy development. Family discord, absence of affectional ties and presence of quarrels and fights affect a child adversely. A child coming from a family with interactional problems is prone to nave emotional difficulties and poor scholastic performance. Children have more problems if the disharmony occurs in the parental unit, though any family discord has adverse effects. A child from a noisy, quarrelsome family might take on to delinquency, perform badly in school or be depressed.

b) Organisation

Family organization refers to the structure of the family i.e. the number of people, presence of parents, leadership patterns and necessary functions of a family such as disciplining patterns. An overcrowded family, with multiple parenting can lead to problems in the children. On the other hand small families which are socially isolated or where both parents work may make the child prone to emotional and intellectual deprivation. Whatever the size of the family, presence of factors that lead to child neglect and understimulation are identified as being high risk.

c) Parenting

The presence of too many parental figures with differing view points on child care, might lead to inconsistent disciplining. On the other hand the absence of one or both parents in a family leads to a number of emotional and behavioural patterns in the child. Families where one parent is away for a long time, or there has been a divorce or death, put the child in a vulnerable position.

d) Routine

The absence of a family routine is also an important risk factor – routine includes, rules for various acts such as sleeping, bathing, work and play. A

family with no routine leads to lack of discipline in the child and absence of a work or play habit, leading to behavioural problems.

e) Disciplining

Organization in a family also includes disciplining patterns. Both extremes of disciplining are faulty and can lead to psychological problems. A harsh, punitive parent is as much a risk factor as poor, inconsistent disciplining.

f) Psychosocial Stimulation

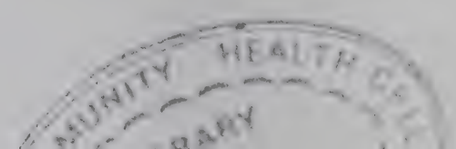
At times a family may be functioning fairly normally in all other areas except in communications and group activity. Children belonging to this family are prone to develop problems in the area of language, social skills and cognitive development. Not involving the child in play, inadequate conversation and lack of playmates at home and in the neighbourhood render a child vulnerable to a number of cognitive and emotional problems. If both parents are working and there is a dearth of caretaking such problems may arise.

3. ILLNESS IN THE FAMILY

Presence of a chronic or terminal illness in the family, particularly in the parenting figures poses a risk for the normal development of a child. A physically ill parent cannot perform his/her duties and might have frequent separation from the child due to hospitalizatio. Mental illness in parents, specially in the mother leads to constant understimulation or problems in disciplining and communication, causing stress in the children. A depressed parent may not follow routine, be inconsistent in disciplining or may not be emotionally warm towards the child. A psychotic parent on the other hand by her/his erratic behaviour and inconsistency may cause emotional problems in the child. Use of alcohol in any family member by virtue of discord and neglect is also a major risk factor.

It should be emphasized that though children in the above families are 'at risk', all of them may not go on to develop serious problems because of their own strengths and other support systems such as school, teacher and other family members. However it is important to intervene in any family with risk factors to prevent problems from evolving in any child.

Based on the above discussion of high risk families, a method was evolved by which, such families could be identified easily. There are certain indicators in a family which can sensitize us regarding the presence of



these risk factors. These have been summarised in the Home Risk Card (HRC) which is a tool to detect and rate the presence of some of the more important risk factors. It should be mentioned here that the HRC tells us about only certain risk factors – the presence of any other risk factors should be additionally looked into by the intervention workers.

HOME RISK CARD

I Adverse Neighbourhood Environment :
(not at all conducive for child's proper growth and development)

II Abject poverty:
(the family has difficulty even for food/clothes, or cannot afford any play material for child)

III Poor house keeping:
(Unclean house, poor house routine, unclean children)

IV Characteristics of mother:
(She remains sad or depressed for long periods without reason or often gets upset easily)

V Severe marital discord:
(There are often serious problems among the couple, conflict over money matters, drinking habits or general dissatisfaction with married life)

VI Neurotic traits:
(bed wetting or stammering in any child in the house in age group 3-6 years)

VII Child neglect:
(for any child in age group 3-6 years)

(lack of interest/affection and lack of routine, child gets frequent beating or is blamed often lacks playmates)

SCORING:

1. Yes 2. No 3. Not certain

CHAPTER – 5

Family Interventions– General Guidelines and Specific Interventions

General Guidelines

Now let us say, you have identified a family at risk. You should know certain things to execute intervention. Our intervention consists of sensitisation of the family to the risk factors, talking to family members, advising them, giving suggestions that suit them and encouraging them as they make these new changes. One thing to be remembered is that a family's conditions cannot be changed totally and within a short span of time. Not being able to bring about visible changes in the family should not be considered a failure on the part of the worker. Each problem needs to be dealt with in different ways. The following part of the chapter deals with assessing the nature and extent of the family problem, identifying resources to be used in intervention and finally helping the family to change.

A. Assessing a Family Problem

Whenever you are approaching a family for intervention, remember that they have a better knowledge of their own strengths and weaknesses than you do, so do not try to force change. Initiate conversation and discuss problems in such a manner that they feel the need for help and a need for change. Remember that only when a family or a family member is motivated for change will behaviour be altered.

As far as possible, try and meet the whole family or as many members as possible to understand how the family is functioning. There are certain areas of family functioning that you should specifically look at to arrive at the identification of risk factors and resources. These are

1. **Identifying the leader:** Find out if the family has a leader or is there shared leadership (for eg. two brothers, husband and wife) or is it a leaderless family? This is important as change can usually be initiated through the leader.

2. **Emotional atmosphere:** Do the family members behave cordially with each other, do they share emotions and feelings, is there a 'we' feeling in the family?

3. **Adequacy of role:** Every member has a certain role in the family – eg. the mother is a housekeeper, a wife, a mother and her job is to manage the family routine. Evaluate whether each family member is fulfilling his/her role. Is there role strain (Too many roles that the person finds difficult to manage)? Specially, where a person is physically or mentally ill, the roles will be affected and will hamper optimal functioning of the family.

4. **Communication:** How much do family members talk to each other? Are there frequent quarrels and misunderstandings? Do they praise each others efforts? Do parents spend adequate time with each other and with the children?

5. **Support Systems:** What kind of support does the family have? Do they have people whom they can rely on in times of crisis? What is their relationship with neighbours and relatives? Is there any religious or other organization that can help them in times of need?

B. Identification of Resources

Every individual or family, however distressed or troubled, has certain resources which help in coping with problems. It is necessary that these are identified and supported in order to enhance coping. Some of these internal attributes may not be identified by disturbed individuals and it is the task of intervention workers to highlight these positive resources.

1. Individual Resources

- Skills and abilities of an individual such as his/her knowledge about his family's needs.
- Willingness to cooperate in the intervention.
- Adequate coping ability.
- Possessing any skill or ability which enables him or her to help the family materially.
- Ability to act as a mediator or peace maker in the family, depicted by the ability to solve problems in the past, handling crisis and not being depressed and maintaining a positive attitude despite problems.

2. Family Resources

Though some families may appear dysfunctional, we should always remember that every family however troubled, has its own strengths. It is the task of the intervention worker to tap these resources and utilize them in therapy.

The positive attributes of any family are as follows:

- Adequate understanding and positive interactions within themselves and with neighbours and relatives.
- A strong marital relationship or parent-child bond or any other healthy relationship in the family.
- Evidence in the past, of the family handling crisis and problems by getting together and generating resources.
- Adequate family support.
- The ability to communicate emotions and feelings with each other.
- Good caregiving specially to the elderly & children as reflected by immunization, health status or nutrition.
- Good moral and religious standards.
- Adequate discipline.
- The 'we' feeling or presence of family cohesiveness.
- Adequate family routine.
- Economic stability.
- Presence of a leader or person from whom counsel is sought and followed.

3. Community Resources

- Presence of community leaders,
- Governmental and non-governmental agencies,
- Existence of effective family programmes like supplementary nutrition / family welfare / Anganwadis / Balwadis / School developmental programmes,
- Adequate support from neighbours, relatives and friends,
- Primary health centres and creches.

Strengthen these resources and utilize them properly to make your intervention meaningful and enhance the positive aspects in the family.

Once you have evaluated the family in all these areas you can now arrive at some conclusions.

1. **What are the problem areas in this family?**
2. **What are the strengths of this family?**
3. **What is the first area you would like to change?**
4. **Who are the family members you would like to involve in intervention to begin with?**
5. **Are there any external agencies that you would like to approach for help?**

ATTITUDES OF THE WORKER IN THE FAMILY INTERVENTION

Your intervention keeps you in close contact with the family members. Your attitudes towards the family and the process would have far reaching effects on both. And hence, it would be necessary to be aware of certain tenets before you start your intervention. Here are certain do's and dont's for you to follow:

a) Accept the existing family beliefs about any topic and do not contradict them.

b) Show interest in individuals. Do not see them as problem people.

c) Listen with interest to what people have to say.

d) Let a person share his feelings, even if you don't agree entirely.

e) Refer to the previous conversation that you have had with him/her.

f) If a person becomes silent when you direct a message to him, don't feel irritated. His silence may mean that either he has not understood or that your ideas are not acceptable to him or that he is thinking over it.

g) Encourage the person to express his emotions and feelings such as anger, irritability and distress.

h) Do not take an attitude of judgement.

i) Recognize the needs of the person.

j) Anybody feels uncertain when assigned a new task, so provide reassurance.

k) Involve the community or group when needed, because an individual accepts the change easily when his group is involved and this change lasts longer.

l) Show empathy and understanding to the person's problems.

m) Give them only suggestions and not solutions.

GUIDELINES TO FAMILY INTERVENTION

Here are some guidelines to show you how to go about the intervention programme:

1. You already have certain tasks assigned to you. This intervention is only a part of the work you are already doing. It is best that the intervention is incorporated into your other tasks and becomes part of your routine way of handling individuals and families regardless of the programme undertaken.

2. Find out the specific risk factor in the family on one or more of your family visits. The HRC helps you to do this. The problem which the family wants solved first should be attended to immediately. If there is more than one risk factor, intervene in the area which the family perceives as most problematic.

3. Decide on the person to be involved and counselled in the family to help solve the problem.

4. Try to elicit active participation from the persons who matter, because ultimately they are the people who should improve their family conditions. But do this gradually and stepwise depending on the co-operation of the family.

5. Your intervention should be simple and flexible.

6. For the purpose of intervention you will have to perform a few tasks with the family members. So, list out a few simple tasks and demonstrate.

7. Show active involvement and understanding in executing the tasks.

8. Praise and appreciate family's efforts. This increases their sense of improvement. If necessary, when you see changes, demonstrate them to the family. This gives them more confidence.

9. Do not be directive or force a family to change. Instead show them the need to change and demonstrate healthier ways of functioning.

10. Do not act as a judge or take sides. Try and understand each person's actions and behaviour and motivate them to change gradually on their own.

11. Remember you cannot solve all the problems in a family. Your task is to initate the process of change and show the family how to handle problems. Subsequently, the aim is to help the family solve their problems themselves.

12. Do not feel upset if you cannot change a family despite all your efforts. Remember, a family will change only if it feels the need. If a particular strategy is not working try a different approach but do not get disheartened if things do not work. May be the family wants to stay that way.

METHOD OF INTERVENTION

Once the problem is identified the intervention worker should take the following options for initiating change.

1) Education.

2) Problem solving i.e. helping discussions among family members regarding the problems and arriving at a solution and counselling.

3) Referral to, or involvement of another agency.

1) Education

Very often families behave and do things in a certain way because of lack of knowledge and awareness. Educating them about these issues might be enough in solving minor problems in the family. Explaining to the family regarding normal psychosocial development of the child, the role of the family in the promotion of cognitive and emotional development and

indicating how certain family problems such as disharmony and inadequate stimulation can harm a child, by itself may lead to improvement in family functioning. Education is thus an important ingredient of any intervention programme.

2) Problem Solving & Counselling

Under certain circumstances education alone may not be enough because of the severity of family problems. When a family is preoccupied with its own problems, they may not be able to assimilate knowledge even when provided to them.

Under these conditions it is advisible to keep education for a later date and find solutions for the family's more pressing problems. The intervention worker should organize family meetings in which issues are discussed and solutions reached. This can be done by using the following approach :

1) Delineating the problem in into smallest component parts.

2) Identifying the most important problem (part to be changed).

3) Offering solutions to the problem (which is done by the family with the help of the intervention worker).

4) Discussing pros and cons of each solution.

5) Implementing the solution which seems to be feasible (based on pros and cons).

6) Evaluating the solution after it has been implemented.

7) Praising change made in the family.

This simple approach can be followed by the intervention worker. initially, he can be part of the group and once a family learns to solve its own problems, the worker can gradually recede.

In addition to problem solving, the worker should encourage healthy communication of emotions and feelings between family members. He should encourage all the members to discuss issues and arrive at solutions amenable to all of them.

Counselling: It is necessary to counsel the family regarding various issues. But it should be simple and acceptable to the family. The following counselling techniques can be used.

a) *Positive Feedback:* It is always important to notice positive aspects in any family and also demonstrate it to them. This boosts their morale and motivates them for change.

b) *Emotional support:* Providing emotional support to the family members, especially the mother will be an essential part of any intervention, as it would reduce mental tension to some extent and create trust towards the worker.

c) *Negotiating between family members:* The worker may sometimes require to negotiate between different members in a family, say for eg. between husband and wife in case of a severe marital discord. The worker should also be able to demonstrate regotiating skills to the family members. This will also help them in resolving issues fighting.

d) *Identifying hindrances in behavioural change:* There could be many problems and obstacles in bringing about change in a family. It is very essential for the worker to identify these problems, rather than blaming the family for not changing.

e) *Using resources for the family:* The worker needs to identify and utilize resources when necessary. There may be individual, family or community resources.

3) Referral to or Involvement of an External Agency

At times it might be necessary to seek help from an external source such as a relative, friend or an official agency. Issues regarding health (mental and physical illness) will require referral to the appropriate hospital while employment needs may be met by the other agencies. If the worker feels the need, he can involve relatives and friends or other community members in helping solve the family's problems.

Specific Intervention for Individual risk factors

All the while, we were talking about certain general guidelines necessary for carrying out the intervention. Now, let us come to the specific risk factors and their intervention. The HRC helps you identify the following 7 risk factors-adverse neighbourhood environment, abject poverty, poor house keeping, characteristics of the mother, severe marital discord, neurotic traits in children and child neglect. How do you intervene in these cases?

1. Adverse Neighbourhood Environment

If the conditions in the neighbourhood have to improve, like keeping it clean, noise free and devoid of quarrels and antisocial behaviour, the

community has to work together. When there is total involvement on the part of the community they can reduce most of the risk factors in the neighbourhood. But, for this you will have to try and involve the people more and more and take the help of the Governmental Organisations like the City Corporation, Village Panchayat and so on; or Non-Governmental or Voluntary Agencies like CCF, doing this kind of work. The family on its part can try and keep good relationships with the neighbours. Your can tell them how it helps, with the neighbours reciprocating the same feelings and thereby a more cordial atmosphere would ensre.

2. Abject Poverty

In a family with abject poverty conditions, you will first have to look for any resources available in the family. If there are any, you can help them by telling them ways of generating additional income to the family. To do this, you need to be aware of the such programme going on around your area of work. In families where there are no ways of supplementing the income, you can tell them how their budget can be planned well. They can eat nutritious food which is not very costly. They can make toys with things at home for the children, say for example, with a coconut shell or a waste piece of wood.

3. Poor House Keeping

We find many families who do not have a regular house routine and are kept badly. After discussing with the mother what are her problems in keeping the house neat, you can advise her and help her in improving her house keeping habits. Good house keeping has a strong effect on children's health. It prevents certain diseases and it promotes good health. A regular routine in the house makes the children responsible individuals as they grow up. Good house keeping would mean:

a) **A clean house:** The house should be swept neatly everyday. The cobwebs should be removed because dust and filth inside the house generate foul smell and cause disease. Things around the house should be arranged properly and not thrown around haphazardly. Vessels used for daily cooking, eating should be washed thoroughly. The family members should see that there is no standing water anywhere around the house because this breeds mosquitoes which in turn cause disease like Malaria. Every house should have a latrine a little away and this should be kept clean. Children should not be let to play near it. Vegetables and other

plants can be grown around the house. These vegetables are fresh and good for health and keep the surrounding area of the house clean.

b) **Clean Children:** The children should be bathed every day and should wear washed clothes. Their hair should be combed regularly to avoid lice. Their nails should be cut regularly and kept clean. Otherwise dirty nails cause germs to get into the stomach while eating and cause diseases. Regular cleaning of the mouth – teeth after eating food, washing hands after every ablution and not to spit anywhere and everywhere. The family members should develop a habit of washing hands before eating and keeping eatables and water covered.

c) **Characteristics of the mother:** Here you can help the mother cope with problems in a better way. You will be lessening her burden by just listening to her problems. Your understanding of her problems would give her more confidence. But in case of any serious psychiatric illness, it is better to refer her to the psychiatrist. You can continue to visit her, talk to her and see that she takes the treatment regularly.

5. Severe Marital Discord

The couple require your counselling and advice. You can tell them about simple things which would improve their marriage.

a) They can recognise each other's worth.

b) Appreciate each other openly.

c) Discussing matters and taking decisions together for example: Sending the child to the school, budgetting, visiting relatives.

d) Not quarreling in front of children.

e) Expressing ones needs and expectations openly.

You can assign them simple tasks which they should adopt later on. For example: the wife may feel that she is overburdened and wants her husband to help in small chores. If the wife can discuss this problem with her husband and they can be helped to mutually arrive at some decision regarding sharing of household chores. The time that the wife saves can be used by her to do things for her spouse.

6. Neurotic Traits in Children

Apart from assessing the physical milestones of development of the child, it is important to assess his psychosocial development. If he has not stopped bedwetting even after 3 years, refer him to a doctor for physical

examination. If there is no physical disability, you can teach some simple skills of toilet training to the mother, like :

a) Avoid giving water to the child after late evening.

b) Encourage the child to pass urine just before going to bed.

c) Do not shout at the child and help him gradually to adopt regular toilet habits. Be casual about it. Make his day happy and relaxed.

e) Whenever he has not wet his bed, reward him with a sweet or something or appreciate him. Dry bed in itself is an effective reward.

f) A quiet period before bed time and warm bed room is advised.

g) Make him feel responsible to stop this habit.

h) When he wets he may be asked to mop the floor and change his clothes, not as a punishment but as a way in which he can cooperate.

There may be several reasons for this like too strict training, jealousy about brother or sister, tension about first days of school, insecurity and so on.

If a child has the problem of stammering, you can tell the family members to be more affectionate and understanding towards him. They should avoid making fun of him as far as possible. This increases his sense of security and he gains more confidence. Gradually he would improve. The parents and other family members should speak to him slowly which would help him to improve his speech.

7. Child Neglect

A child requires attention from parents and family members, for good psychosocial development:

a) Parents and family members should be affectionate and caring towards the child.

b) Physical closeness like hugging the child is important.

c) Some one in the family should stimulate the child by playing with him, telling stories and so on.

d) Avoid beating the child. At the same time don't encourage temper tantrums. The child should have proper discipline.

e) Don't humiliate the child and compare him with the other children in the family or neighbourhood.

f) See that the child has a regular routine like fixed timings for food, sleeping, studying etc.

g) The children should be allowed to play with other children of their own age.

h) A word of appreciation for each good act in the child, makes the child happy.

i) Verbal abuse can be as painful as physical abuse and should be avoided. Instead the child can be disciplined by being firm yet not abusive.

j) Spend some time with the child everyday (this can be done either by one of the parents or together as a family).

CHAPTER – 6

Illustrative Cases

Here are a few 'real life' cases that need intervention. So, let us see how we can intervene in different families and help them, using the various methods explained in the previous chapter.

Case I: In this family both parents are casual labourers. They have four children. Their age ranges from 9 years to 1 1/2 years. The eldest child has a daughter. As both parents are working, she looks after the house and younger children. She does not go to school and has not even attended Anganwadi centre. There is abject poverty and the family is rated as disorganised. The children are unclean and look adequately nourished and are immunized. They attend the Anganwadi centre quite regularly. the father's sister lives nearby and helps the girl whenever necessary. She has taken interest to send the two children to the Anganwadi centre and sees that they attend regularly.

Risk Factors

1) Abject poverty

2) Disorganized, Unclean home/unclean children.

3) Child neglect/Indifferent parents.

Resources

1) Regular attendance to Anganwadi Centre.

2) Children immunized/adequately nourished.

3) Father's sister helping out.

4) The eldest daughter looking after the home.

Entry Point: As the parents were not available, the girl was talked to about the work at home, how she manages and so on. She was appreciated for looking after the house and children so well. As she seems to be a clear resource in the family, she was used as an entry point to the family.

Intervention Plan: The family may be advised to make a proper utilization of the help they are getting from the father's sister. The parents may be counselled regarding the importance of stimulation and spending time with children. The worker along with the family may plan out the ideal time say for eg. dinner time and see that the family carried out the task given to them. A healthy and more positive interaction between parents and children may be encouraged.

The parents may be encouraged to give the elder girl some basic education as she is still very young. She may explain the necessity and importance of this to them.

There may not be much that a worker can do to remove abject poverty, however she can talk about budgeting, proper utilization of the available resources, nutrition at a low cost, and discussion of other ways of earning livelihood.

The worker can help the mother in planning out her routine. The daughter may also be encouraged to help in chores around the house. Along with this the worker can teach cleanliness to the mother. She may explain its importance to her and help her and encourage her in making changes gradually.

The worker needs to give a positive feedback to the family, and involve herself in the tasks given to the family, whenever necessary.

Outcome: Parents taking more interest in children, better child care, more organized and clean home and children. Better relations between parents and children, despite the economic status of the family remaining almost the same. They can plan their budget and provide nutritious meal which costs less and things available at home for play. Parents may take interest and there may be more organization in the family.

Case 2: This family has four children. The eldest is eight years old and the youngest about one month old. The husband is a casual labourer (coolie) and wife works as house maid. They have not followed birth control. The father drinks. The children are unclean but look quite healthy and are immunized. The children attend Anganwadi regularly. Eldest goes to school. The mother is quite motivated. Poor house keeping was noticed. The second child has scabies. The family does not have any serious financial problems. The parents are worried about the scabies of the second child to a certain extent.

Risk Factors

1) Unclean children

2) Poor house keeping

3) No birth control

Resource

1) Regular attendance to the Anganwadi centre

2) Good health and immunization to children

3) Mother motivate/supplementing income to family

4) No abject poverty

5) Parents concern about the children

Entry point: The mother was appreciated for getting the children immunized and she was told that her children look quite healthy. Seeing her concern the mother was talked to about the scabies noticed in the second child and was told how it is important to keep children and the house clean to avoid such skin diseases. She was asked to get immediate medical care for the child.

Intervention Plan

This family has many positive aspects for eg. having no major financial problems. The worker may demonstrate these positive factors to the family which will motivate the family towards change. However, they may be advised about proper utilisation of available resources.

The mother needs to be advised regarding cleanliness, demonstrating the example of the child having scabies which the family too is concerned about. The worker may help the mother to plan her routine more systematically. She may explain to the mother how it helps in making the children more responsible as they grow up.

The wife may talk about her husband's drinking habit. The worker may negotiate between them in this regard if necessary and feasible. If there is no change, the worker should not fell disheartened, she can lend emotional support to the mother and encourage the husband to seek medical help for decreasing the habit. She can help the wife initiate discussion with her husband. If this does not help, she may intervene and negotiate issues between the couple with the aim of altering some of the factors that might

be leading to drinking eg. Wife's nagging, inability to cope with stress or the influence of friends.

Outcome: Mother being motivated, started giving better care and stimulation for children. They were kept clean and the house was also kept better. Further she would agree for birth control. The father has not stopped his drinking habit, but he says that he is trying to reduce it. He spends some time with the children.

Case 3: The family has five children in the age range of 10 years to 1 1/2 years. The mother is pregnant again. They have not followed birth control. Both of them work as casual labourers. Father is alcoholic. He had an attack of TB two years ago. He was advised against taking alcohol. He had stopped momentarily but has started drinking again. Children are healthy and immunized. Elder child goes to school and young ones attend the Anganwadi. There is abject poverty. The mother feels overburdened with work. The parents have frequent quarrels and the mother is not happy with marriage. She has been wanting to leave the husband but has not done so for the sake of society and children.

Risk Factors

1) Abject poverty
2) Severe marital discord
3) Over burdened mother
4) Alchoholic father
5) Over crowding in the family

Resources

1) Regular attendance to Anganwadi Centre
2) Elder children attending school
3) Parents motivated
4) Good health/Immunization for children

Entry Point: Mother was talked to about her over burdening. She was appreciated for getting her children immunized and was told that her children look quite healthy. Her problems were discussed in detail and the worker empathized with her. This further motivated her to discuss her other problems.

Interventions: The entry point being discussions regarding the mothers overwork, would usually lead to ventilation of her emotions to some extent and understanding of the advice and suggestions of the worker.

To handle the strain of work and children, the worker may encourage and negotiate among the family members so that the work is distributed equally and is not a burden on the mother alone. The worker may need to see the couple together for this.

Birth control may be advised to this couple since there are already five children and the mother is pregnant for the sixth one. She may explain the adverse effects it will have on the physical and mental health of the mother and thereby making her incapable of looking after her children well.

The father needs to be encouraged to make small changes in sharing of work and initiating birth control which may reduce the discord automatically. This may not be so easy to change but an effort can be made to better the communication pattern. They can be given tasks of spending time together with children or having some family rituals like prayer etc.

The father's drinking habit may be difficult to change and one might face resistance, however discussions regarding the effects of alcohol can be initiated.

As for abject poverty, they may be taught budgetting, low cost nutrition and play material and making effective use of existing resources.

The positive aspects in this family like healthy children, immunization, regular attendance to Anganawadi centre should be appreciated.

Since this family has too many risk factors it would be necessary to deal with each risk factor carefully and bring about change gradually. Since the risk factors are related t one another, intervention with one may cause some change in another.

Outcome: the mother feels relieved with someone sharing her problems. The couple followed the advise and the number of quarrels, specially in front of children has come down. They have agreed for birth control realizing the difficulty over crowding is causing them. The father is trying to help the mother out some times. But has not yet stopped drinking.

Case 4: This family displays abject poverty and disorganization. The mother is employed as servant maid. The mother has five children. Three of them are below six years. All the children are immunized and attend the Anganwadi Centre. The younger child bed- wets. The elder children go to

school. She hopes to make them study well and come up in life. the husband drinks and quarrels with the mother he does not support the family. The mother is ignorant about children's needs for healthy development, though she cares for them very much despite being overburdened with work.

Risk Factors

1) Abject poverty

2) Over crowding

3) Disorganized home

4) Marital discord

5) Neurotic trait in the child

Resources

1) Children are immunized.

2) Mother provides financial support

3) Mother's caring attitude/ambition for a good future for children.

Entry point: The mother was asked about her overburdening and was appreciated for managing it and at the same time caring for the children. With her caring attitude she may be naturally concerned about her child's bedwetting habit, and academic success of her children.

Intervention Plan: In this family the mother seems to be a very resourceful person. In spite of having more children, she is giving adequate care and supplements the family income. This may be appreciated by the worker. This will motivate her to learn more about need for a healthy psychosocial development of children. She may be gradually taught about these and made to learn through guarded tasks.

Simple toilet training techniques may be taught to her to control the bedwetting habit in the child.

She can also be explained about budgeting which will help her use the resources better.

The worker may gradually help her to become more organized and systematic in house work.

If may be necessary to negotiate with the husband to make slight changes to help his wife. The couple may be encouraged to appreciate each others' positive aspects and also communicate their needs to each other eg. the wife may want the husband to spend more time at home, while the husband may want her to be more organized at house work or decrease her nagging.

Outcomes: A family with 7 children displays adject poverty. But the house is quite organized and the children look quite healthy and clean. Mother is aged 49 years. All the children are attending school except last one who goes to Anganawadi centre. Mother is a housemaid and cannot take very good care of her children. Father though helps economically to a certain extent, is passive. The mother feels overburdened and gets upset easily. She shouts at her husband, children, is irritable most of the time. But despite all this she sees that her children attend school regularly. She feels that she has too many children and too much work because of which she cannot look after the children and house properly.

Risk Factors

1) Abject poverty

2) Overcrowding, lack of spacing and birth control.

3) Passive Father

Resources

1) Children are attending school/good health and cleanliness in them.

2) Organized home.

3) Mother supplementing income.

4) Coping potential of the mother.

5) Mother's concern about the children.

Entry Point: To show the mother how much she is already doing for her children and home despite all her difficulties. She must be appreciated for this. Using her concern for children as an entry point, you may further look into the other problems. She has enough justification for getting upset and irritable with so many problems. But she can be demonstrated how it might adversely affected the development of her children.

Intervention Plan: In this family, the mother has a relatively high degree of irritability. To reduce this, her routine may be enquired into, in detail. The worker, may help her to plan her routine properly so that she will not

feel the burden. It may also be necessary to negotiate among the family members in this regard.

Appreciate the family that, inspite of many difficulties, there are positive aspects like an organized home, clean children and their regular attendance at school. By highlighting these positive factors, motivation can be brought about easily.

As for the father, he can be explained about the importance of his role as a father, he can be explained about the importance of his role as a father in a healthy psychosocial development of his children.

The couple can be advised to spend some time with the children. This will bring them closer.

Outcome

1) Better relationship between parents.
2) Better stimulation for children.
3) Father taking more interest in family matters.
4) Mother feeling more happy/reduction in her irritability.
5) Birth control may be adopted.

Case 6: This family can be rated disorganized. The mother is a housewife. Father works as an attender in a private office and the family has enough money for basic needs. They have three children. The eldest is 6 years old, the second is 3 years and the third about 1 1/2 years. The children do not attend the Anganwadi centre regularly. They are not immunized. the third child looks undernourished. The mother does not show any interest in the family matters. She sits in a place for a long time. Some times she laughs to herself and does not care about her appearance. Sometimes she makes gestures as if she is talking to somebody. Father's mother aged about 60 years stays with them. She has to look after the house inspite of her old age. The worker has not been able to do anything to help the mother because she does not seem to understand anything. The father is worried about this and he shouts at her sometimes for not looking after the children.

Risk Factors

1) Psychiatric illness in the mother.

2) Disorganized home.

3) Child neglect.

Resources

1) Adequate resources for basic needs.

2) Father's mother staying with the family.

3) Father's concern about his wife and family.

Entry Point: The major concern being the illness of the mother, the worker can ensure treatment for the illness. This brings about little hope in the family.

Intervention Plan

In this family, the mother has a psychiatric problem, for which she may need expert advice and care. The worker should encourage the mother to see a doctor and help in follow-up and drug compliance. The other family members should be explained that the mother's behaviour is not deliberate and that she has some psychiatric problem. Since the grandmother is at home, she should be encouraged to help in child care. Her efforts in this regard should be appreciated. The father should be explained about his increased responsibility. The worker may help to plan his routine and may extend emotional support.

If may be necessary to make use of the resources outside the family like neighbours, relatives and friends for child care since the grandmother is very old.

A family with a mentally ill patient will need special attention and care. The worker might be able to help the children by giving extra time, involving them in play and encouraging them to interact with other kids. Any stigma in the community that exists because of the mental illness should also be dealt with by education and information.

Outcome

1) Improvement in mother's condition.

2) Birth control measures adopted.

3) Better coping/more confidence in the father.

4) Better father-children relationship.

5) Good routine and stimulation for children.

CHAPTER – 7

Outline of Steps in Family Intervention

Step I: Identification of Risk Factors

With the help of HRC / other family factors :

eg. 1) In environment–Poor condition of the family

Unclean house and neighbourhood

2) In family

Alcoholism, violence, mental symptoms

3) In children

Assessment of problem behaviours of children like aggression, shyness, delayed milestones.

Step II: Identification of Resources

- In family–any responsible, understanding family member.
- In environment–Govtl. & Non Govtl agencies, Anganwadi, PHCs, Developmental programmes and so on.
- Any other–Care given by relative, neighbour or friend.

Step III: Selection of Entry Point

- As a part of the tasks already being done by the worker eg. health education, nutrition program etc.
- Tasks should be perceived as needed by the family.
- Tasks should be acceptable to the family.

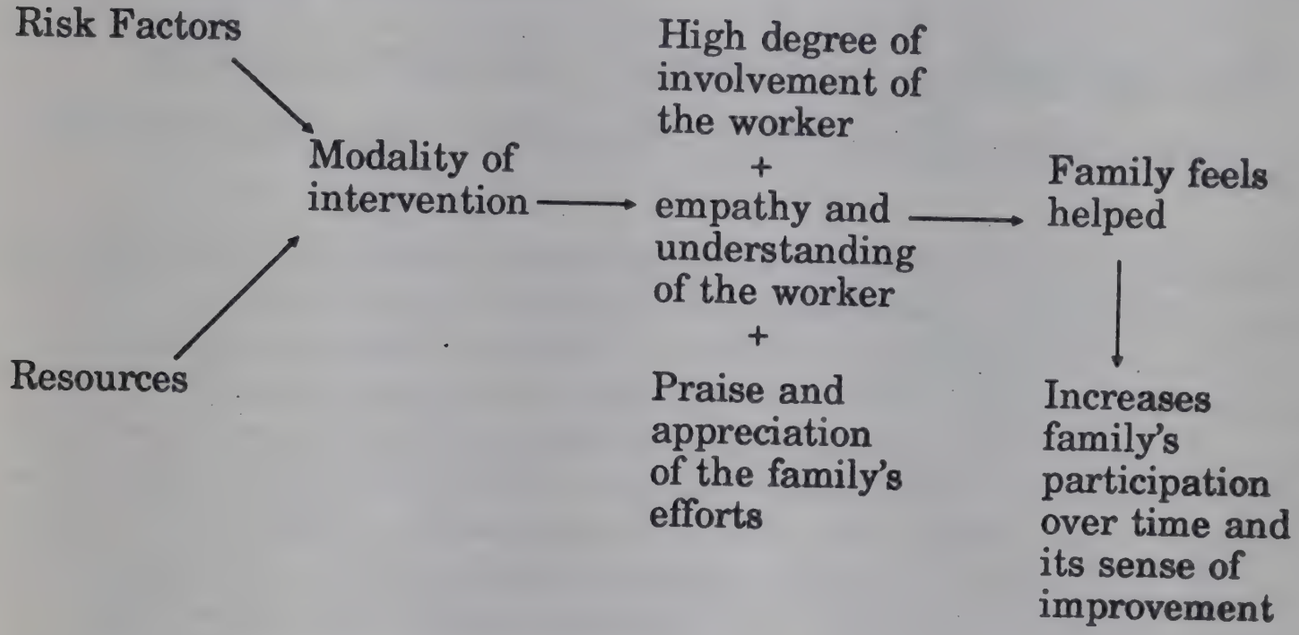
Step IV: Developing Plan of Intervention

- List series of tasks to be jointly performed by the family and the worker.

— Tasks should be feasible and simple.

— Tasks should be flexible.

Step V: Actual Intervention



CHAPTER – 8

Integration of Family Intervention into the Existing Health Services

An important aspect that must be remembered at the end of reading this manual is that family counselling and intervention can be used as part of any health care programme. Regardless of whether the contact is made for tuberculosis and malaria control or for family planning measures, a health worker can adopt family counselling techniques and use this as a means of changing behaviour in the family. This will ensure better acceptance of the programme by the family and enhance participation. The use of family counselling techniques is specially useful in families which are resistant to change and where exclusive use of educational methods has not worked.

It is important hence for every health professional to adopt these methods in his day-to-day practice with individuals and families to increase compliance and acceptance of the health care programme.

In conclusion, we would like to mention that each child or individual should be viewed with his family in the background. Day-to-day behaviour and living problems such as nutrition, child rearing, hygiene, mental well being and help seeking with regard to health are strongly influenced by the family's own views and life style. Any inputs in the above areas without involving the whole family may result in poor results in those who are unmotivated for change.

It is hence important that the family be involved in all programmes and even if the family intervention is not implemented as a whole in all the families atleast some aspects of counselling and intervention can be used in most families to ensure success.

APPENDIX I

INTERVIEW SCHEDULE FOR IDENTIFYING CHILDREN AT RISK OF POOR PSYCHOSOCIAL DEVELOPMENT

Family Sl. No.:

I. NEIGHBOURHOOD ENVIRONMENT

(a) Do you think that environment of your neighbourhood is conducive to your child's proper growth and development. ☐

1. Very much
2. To some extent
3. Not at all

(b) Are the people in your neighbourhood of the some socio-economic status as you are? ☐

1. Very much
2. To some extent
3. Not at all

(c) Do people in your neighbourhood indulge in fighting, gambling, abusing, shouting and any such other activities? ☐

1. Very much
2. To some extent
3. Not at all

(d) Do you generally have good relations with your neighbours? ☐

1. Very much
2. To some extent
3. Not at all

II. FAMILY STRUCTURE AND SITUATION

(a) Type of family? ☐

1. Nuclear
2. Joint
3. One parent family

(b) Has there recently been a death or separation of a family member to whom child was closely attached to? ☐

1. Yes
2. No

(c) Are there serious problems and/or frequent quarrels between you and any other member in the family? ☐

1. Often
2. Sometimes
3. Hardly ever
4. Not applicable

(d) Do you think that all members of the family share, support and promote the growth of the child? ☐

1. Very much
2. Quite often
3. Not at all

III. ABJECT POVERTY

(a) Do you find it difficult to provide basic demands of your child/children like food, clothes, etc? ☐

1. Often
2. Sometimes
3. Hardly ever

(b) Do you find it difficult to meet the demands of your child/children regarding play material? ☐

1. Most of the time
2. Sometimes
3. Hardly ever

Points of Observation

(c) Type of house? ☐

1. Kaccha
2. Pucca

(d) No. of family members per room? ☐

(e) Cleanliness of house? ☐

1. Good
2. Average
3. Poor

(f) Evidence of poor house routine? ☐

1. Yes 2. No

(g) Children unclean? ☐

1. Yes 2. No

(h) Play material available at the time of visit? ☐

1. Yes 2. No

IV. PERSONALITY CHARACTERISTICS OF MOTHERS

(a) Do you suffer from a Chronic physical or mental illness for which you have to (or were in need of) prolonged treatment? ☐

1. Yes 2. No

(b) Do you feel sad or depressed for long periods of time without reasons? ☐

1. Often
2. Sometimes
3. Hardly ever

(c) Do you get upset easily? ☐

1. Most of the time
2. Sometimes
3. Not at all

(d) Do you fell confident that you will be able to solve most of your problems? ☐

1. Most of the time
2. Sometime
3. Not at all

(e) Taking alcoholic drinks is quite common these days. Do you think it is a healthy social trend? ☐

1. Yes 2. No

(f) Do you take alcoholic drinks? ☐

1. Yes 2. No

(g) Does your husband take alcoholic drinks? ☐

1. Often
2. Sometimes
3. Hardly ever
4. Not applicable

(h) Do you prefer to do all the activities of the child yourself even though he can do these by himself/herself, like feeding, bathing, clothing, etc. ☐

1. Most of the times
2. Sometimes
3. Not at all

(i) Do you normally allow your child to do whatever he wants to do? ☐

1. Most of the times
2. Sometimes
3. Not at all

Points of Observation

(j) Does the mother look desperate/hopeless? ☐

1. Yes 2. No

(k) Is the mother very slow to respond? ☐

1. Yes 2. No

(l) Is the mother absent minded? ☐

1. Yes 2. No

V. SEVERE MARITAL DISCORD

(a) Are there serious problems on disagreements between you and your husband which causes difficulties for you? ☐

1. Often
2. Sometimes
3. Hardly ever
4. Not applicable

(b) Do you think that is usually a solid reason for conflict with your spouse? ☐

1. Most of the times
2. Sometimes
3. Not at all
4. Not applicable

(c) What are usually the grounds on which mutual differences arise?

Money matter?	1. Yes	2. No	☐
Children?	1. Yes	2. No	☐
Drinking habits?	1. Yes	2. No	☐
Others (specify)	1. Yes	2. No	☐

(d) As a result of differences, do you

Stop talking to each other?	1. Yes	2. No	☐
Leave the home	1. Yes	2. No	☐
Become indifferent?	1. Yes	2. No	☐

Face abusive behaviour? ☐

1. Not at all
2. Sometimes
3. Often
4. Not applicable

(e) Do the mutual differences reach the stage of physical violence? ☐

1. Hardly ever
2. Sometimes
3. Often
4. Not applicable

(f) In general how do you feel about your married life? ☐

1. Very happy
2. Quite happy
3. Not happy

Point of Observation

(g) Respondent talks in a rejecting manner about the husband? ☐

1. Yes 2. No

VI. HAVE YOU HAD ANY OF THE FOLLOWING CIRCUMSTANCES DURING THE LAST ONE YEAR?

(a) Change in primary caretaker of the child. ☐

(b) Separation/death of a loved one of the child? ☐

(c) Change of residence ☐

(d) Major loss of income or property ☐

VII. FOR CHILDREN BETWEEN 0-3 YEARS.

(a) Name: ☐

Age: ☐

Sex:

(b) Immunization

B.C.G.	1. Yes	2. No	
D.P.T.	1. Complete	2. Partial	3. None
Polio	1. Complete	2. Partial	3. None

Point of Observation

(c) Mother makes critical comments about the child? ☐

1. Yes 2. No

(d) Playmates of the child present during the visit? ☐

1. Yes 2. No

Weight ☐

Height ☐

Neurotic traits

Have you observed that the child has the following habits?

(a) Thumb sucking ☐

(b) Nail biting ☐

(c) Bed wetting ☐

APPENDIX II

Intervention Record Form

Family Serial No. :

Mother's Name :

Child's Name :

Anganawadi Centre :

Serial No. of the Intervention Worker :

Risk Factors Identified (through H.R.C.) :

1. Adverse neighbourhood Environment
2. Abject Poverty
3. Poor house-keeping
4. Characteristics of the Mother
5. Severe Marital Discord
6. Neutrotic traits in children
7. Child neglect

Other risk factors :

1.
2.
3.
4.
5.

Family Resources :

1.
2.
3.
4.
5.

Entry Point:

Sl.No of the visit	Date of visit	Risk Factors intervened with	Any other new risk factors identified	Changes in the risk factors from the previous visit	Major changes in Family (see Appendix)							
					1	2	3	4	5	6	7	8

Intervention Done (see Appendix VII								Family Reactions (see Appendix 7)								Anganawadi Worker's reactions
1	2	3	4	5	6	7	8	1	2	3	4	5	6	7	8	

Overall change
(every 3 months)

1. No. change
2. Minimal change
3. Adequate change

If no change, possible reasons :

Family Factors Counsellor Factors

Intervention Done (Please tick whichever applicable)

1. Educating the Family
2. Counselling
3. Positive Feedback
4. Problem Solving
5. Emotional Support
6. Negotiating between the family members
7. Identifying hindrances in behavioural change
8. Using resources for the family

Family's Reactions

1. Co-operative
2. Happy anout the intervention
3. Resistance to change
4. Co-operative but unable to change
5. Some of the family members co-operative, others not
6. Change in some aspects others remaining the same
7. Change in most risk factors
8. No change

Major Life Events

1. Separation / death of a loved one
2. Change of residence
3. Major loss of income / property
4. Change in the primary caretaker of the child
5. Birth/new arrival in the family
6. Divorce/separation / death of a spouse
7. Accident / disease in a family member / Hospitalization

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